MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG239 2-27-59 et

1434

CERTIFICATE OF DEATH

Reg. Dist. No. 01411

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort Geo. G. Meade, Md — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton, Md
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: US Army Hospital, Ft Geo. G. Meade, Md	d. STREET ADDRESS: 343-A Patuxent Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First: Robert	Middle: Alexander	Last: Abell	4. DATE OF DEATH	Month: February	Day: 15	Year: 1959
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Sept 12 1938	9. AGE (In years last birthday): 20 yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none	10b. KIND OF BUSINESS OR INDUSTRY: /////	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Thomas		14. MOTHER'S MAIDEN NAME: Rose (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): //////////	16. SOCIAL SECURITY NO.: unknown	17. INFORMANT: Mrs. Virginia Widener, — Address: Same As #2	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Head Injuries
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Automobile Accident — Immediate
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Head Trauma occured during Auto Accident				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: Feb 15 1959	20d. INJURY OCCURRED While at work ☐ Not while at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Reece Road	20f. (City or town): Ft Meade	(County): Anne Arundel	(State): Md

21. I certify that I attended the deceased from 15 February 1959 to 15 February 1959 that I last saw the deceased alive on ____, 19____, and that death occurred at 0405 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James H Glenn M.D. — ADDRESS (Street, city or town, state): USAH Ft Geo G Meade, Md — DATE SIGNED: Feb 15, 1959

PHYSICIAN'S NAME (Type): JAMES H GLENN Captain MC

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 2/18/59	22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery	22d. LOCATION (City, town, or county): Glen Burnie,	(State): Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE: Richard P. Laughlin	ADDRESS: Glen Burnie, Md.	24a. REC'D BY REGISTRAR DATE: FEB 24 '59	24b. REGISTRAR'S SIGNATURE: Arthur L. Frank		

I, the undersigned, certify that I Have picked up the remains of Robbert A Abell on 15 Feb 1959 from the USAH, Ft George G Meade, Md. per Dr Faubert, county corner.

Richard V. Smyth Jr

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1435

CERTIFICATE OF DEATH

01412

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY A. A County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Water Bury Md.
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Maryland b. COUNTY A.A. County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Water Bury Md.
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Catherine Middle U Last Alton
4. DATE OF DEATH Month 2 Day 4 Year 1959
5. SEX Female
6. COLOR OR RACE Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 11-16-1890
9. AGE (In years last birthday) 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Hall
14. MOTHER'S MAIDEN NAME Martha Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Hazel Alton Waterbury Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic Hypertensive Cardio

DUE TO (c) Vascular disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 28 19 58 to 2/4 19 59, that I last saw the deceased alive on 2/3 19 59, and that death occurred at 9:10 a.m. from the causes and on the date stated above.

ACTUAL SIGNATURE [signature] M.D.
ADDRESS (Street, city or town, state) 110 Day St Thurmont Md
DATE SIGNED 2/5/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2-8-1959
22c. NAME OF CEMETERY OR CREMATORY John Wesley
22d. LOCATION (City, town, or county) Water Bury (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese # 108 ADDRESS Worth St Emmitsburg Md.
24a. REC'D BY REGISTRAR DATE FEB 6 '59
24b. REGISTRAR'S SIGNATURE Arthur S. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01413

CERTIFICATE OF DEATH

1409 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A A General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 1114 Chester Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph Middle: Henry Last: Atwell

4. DATE OF DEATH: Month: 2 — Day: 22 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug 19-1874

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER Ret. and Waterman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): A A Co Md

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Clyde T. Atwell Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS

DUE TO

332 x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) CEREBRAL ARTERIOSCLEROSIS — Unknown

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 18 FEB, 1959, to 22 FEB, 1959, that I last saw the deceased alive on 22 FEB, 1959, and that death occurred at 9 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward L. Beck M.D. ADDRESS (Street, city or town, state): 41 Southgate Ave DATE SIGNED: 2/23/59

PHYSICIAN'S NAME (Type): EDWARD S. BECK MD. Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb 25th 59

22c. NAME OF CEMETERY OR CREMATORY: Edwards Chapel Cemt

22d. LOCATION (City, town, or county) (State): Parole A A Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Layton Sons ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR DATE: FEB 25 '59

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01414

Reg. Dist. No. 1410

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 53 Collage Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 153 Collage Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie Middle: Bruce Last: Baker

4. DATE OF DEATH: Month: 2- Day: 10 Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 26-1870

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Millinery

10b. KIND OF BUSINESS OR INDUSTRY: Store

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Alfred E. Baker

14. MOTHER'S MAIDEN NAME: Charlotte Bruen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Charles F Lee Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
420.0
DUE TO (b): Arteriosclerotic Heart Disease — 1 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1, 1957 to Feb. 10, 1959 that I last saw the deceased alive on Feb. 10, 1959, and that death occurred at 1:30 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D.
ADDRESS (Street, city or town, state): 6 SHAW ST. ANNAPOLIS, MD.
DATE SIGNED: Feb. 10, 1959
PHYSICIAN'S NAME (Type): JAMES R. MARTIN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 12-59
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff
22d. LOCATION (City, town, or county): Annapolis (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. M. Taylor Sons ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: FEB 12 1959

24b. REGISTRAR'S SIGNATURE: Arthur E. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01415

1436 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pumphrey
c. LENGTH OF STAY IN 1b: 40 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 315 Key Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 25 (Pumphrey)
d. STREET ADDRESS: 1315 Key Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Beatrice Middle: Beverly Last:
4. DATE OF DEATH: Month: Feb Day: 11 Year: 1959

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 12 Nov 1912
9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Beverly
14. MOTHER'S MAIDEN NAME: Anne Riddle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Amita Beverly Address: 315 Key Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive Vascular Disease — Unk
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m., 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1958, to Feb, 1959, that I last saw the deceased alive on 9 Feb, 1959, and that death occurred at 9:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Reynold B. Lighston M.D.
ADDRESS (Street, city or town, state): 5201 Cherry Hill Road
DATE SIGNED:
PHYSICIAN'S NAME (Type): Reynold B. Lighston Sr
Baltimore 25 Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/14/1959
22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
22d. LOCATION (City, town, or county): Balto. (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Mrs Katie R Williams
ADDRESS: 322 N Schroeder St.
24a. REC'D BY REGISTRAR DATE: FEB 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS. A15ME
BM 2.57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01416
Reg. Dist. No.

1437

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
c. LENGTH OF STAY IN 1b: Life time
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Ludwig Heights Inf.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Same
f. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Raymond — Middle: — Last: Ivy
4. DATE OF DEATH: Month: February — Day: 12 — Year: 19 59
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/12/58
9. AGE (In years last birthday): 1 yrs.
IF UNDER 1 YEAR: Months: 1 — Days: — IF UNDER 24 HRS: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Ivy
14. MOTHER'S MAIDEN NAME: Julia Graham
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Julia Ivy (mother) — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Charred above recognition
916.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Sl. I.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Was in bed on second fl or when I one caught on fire.
20c. TIME OF INJURY: Hour a. m. p. m. 2:40 P.M. Month, Day, Year 2/12/59 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): one
20f. (City or town) (County) (State): Severna Park, Anne Arundel, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave Kraute M.D. M.D
EXAMINER'S NAME (Type): Gustave J. Taubert, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2/12/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-15-59
22c. NAME OF CEMETERY OR CREMATORY: First Baptist Cem.
22d. LOCATION (City, town, or county) (State): Earleigh Hghts., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. B. Johnson — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR — DATE: FEB 16 '59
24b. REGISTRAR'S SIGNATURE: Clifton E. Hines

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01417

Reg. Dist. No

1438

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Severna Park
c. LENGTH OF STAY IN 1b: Life time
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Earleigh Heights Rd.

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: None — b. COUNTY: None
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): None
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Juliat — Middle Ivy — Last None
4. DATE OF DEATH: Month February — Day 11 — Year 1950

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
F	C		11/27/54	4 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Earleigh Heights, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Ivy
14. MOTHER'S MAIDEN NAME: Julia Graham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs. Julia Ivy (mother) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Charred above recognition — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Was in bed on second floor when box caught on fire.
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year: 2/12/59
20d. INJURY OCCURRED: While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): None
20f. (City or town) Severna Park, Md. (County) Anne Arundel (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 2/12/59

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-15-59
22c. NAME OF CEMETERY OR CREMATORY: First Baptist Cem.
22d. LOCATION (City, town, or county) (State): Earleigh Hghts., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. B. Johnson — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: FEB 16 '59
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1

1439

CERTIFICATE OF DEATH

02594

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE
c. LENGTH OF STAY IN 1b 22 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNSVILLE STATE HOSPITAL

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE MARYLAND
b. COUNTY BALTIMORE CITY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE
d. STREET ADDRESS 1519 — MULLIKENS CT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First CHARLES Middle — Last BRAND
4. DATE OF DEATH Month 2 Day 27 Year 1959

5 SEX MALE
6. COLOR OR RACE NEGRO
7 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov 11, 1886
9. AGE (In years last birthday) 72 yrs
IF UNDER 1 YEAR Months — Days —
IF UNDER 24 HRS Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOLDER
10b KIND OF BUSINESS OR INDUSTRY FOUNDRY
11 BIRTHPLACE (State or foreign country) VIRGINIA
12 CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME WILLIAM BRAND
14 MOTHER'S MAIDEN NAME MARGARET BROADWAY

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16 SOCIAL SECURITY NO
17. INFORMANT ADA BRAND Address SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia — hypostatic. — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Senility
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hypertensive Arteriosclerotic Cardiovascular Disease
1442 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Uremia.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-15 19 57 to 2-27 19 59, that I last saw the deceased alive on 27 February 19 59, and that death occurred at 5:40 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE Lionel McHenry Knapp M.D. ADDRESS (Street, city or town, state) Crownsville State Hospital DATE SIGNED
PHYSICIAN'S NAME (Type) Lionel McHenry Knapp M.D. Crownsville Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b DATE THEREOF 3-2-59
22c NAME OF CEMETERY OR CREMATORY MOUNT AUBURN
22d LOCATION (City, town, or county) BALTIMORE (State) MD

23. FUNERAL DIRECTOR'S SIGNATURE Ebay O. Wilson ADDRESS 1000 Brantley Ln
24a. REC'D BY REGISTRAR DATE MAR 10 '59
24b REGISTRAR'S SIGNATURE Curtis E. Fraser

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be forwarded with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01418

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1520 Items 1,2,7 FILED 2-24-59 ef

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Pasadena)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 432 Carvel Beach Road

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore (Pasadena)
d. STREET ADDRESS: 432 Carvel Beach Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First NORMA — Middle FAY — Last BOIES

4. DATE OF DEATH: Month February — Day 13 — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH
9. AGE (In years last birthday): 30 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hsk.
10b. KIND OF BUSINESS OR INDUSTRY: Heck's Co.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Willard Boies
14. MOTHER'S MAIDEN NAME: Balbaca Jewell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Address: Fam. & Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute barbiturate intoxication — INTERVAL BETWEEN ONSET AND DEATH

970.2

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Ingestion of barbiturate
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: 2/13 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Anne Arundel Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S Petty M.D
EXAMINER'S NAME (Type): Charles S. Petty, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: Feb. 13, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): B.
22b. DATE THEREOF: 2/17/59
22c. NAME OF CEMETERY OR CREMATORY: Int. Odenton
22d. LOCATION (City, town, or county) (State): Odenton.

23. FUNERAL DIRECTOR'S SIGNATURE: Kirwan Funeral Home
ADDRESS: 130 E. Fort Ave.
24a. REC'D BY REGISTRAR DATE: FEB 16 '59
24b. REGISTRAR'S SIGNATURE: Clarence A. Kinna

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01419

CERTIFICATE OF DEATH

1441 Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CROWNSVILLE
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: CROWNSVILLE STATE HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution, Res dence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 938 N. Durham St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First ALICE Middle E Last BOOKER

4. DATE OF DEATH: Month 2 Day 28 Year 19 57

5. SEX: F
6. COLOR OR RACE: N
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-10-99
9. AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Kitchen Maid
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md Va
12 CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: John Reed
14. MOTHER'S MAIDEN NAME: Mary Banks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NC (If yes, give war or dates of service)
16 SOCIAL SECURITY NO.:
17. INFORMANT: Margaret Kuehn Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: few days
DUE TO (b): generalized arteriosclerosis — since 1953
DUE TO (c): Chronic brain syndrome associated cerebral atrophy
334X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/16/53, 19____, to 2/28/57, 19____, that I last saw the deceased alive on 2/24/57, 19____, and that death occurred at 10:45 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital
DATE SIGNED:
PHYSICIAN'S NAME (Type): L. BENEDICT
Crownsville, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/5/57
22c. NAME OF CEMETERY OR CREMATORY: Bethlehem
22d LOCATION (City, town, or county) (State): Millington Md

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Pennington
ADDRESS: 1412 E. Preston St
24a RECD BY REGISTRAR DATE: MAR 3 '57
24b REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [redacted] funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01420

CERTIFICATE OF DEATH

1411 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6 Martin St.

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Md
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 6 Martin St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Olivia Middle Last Bright

4. DATE OF DEATH: Month 2 Day 18 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 10 - 1888

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Annapolis Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Joseph B. Hinton

14. MOTHER'S MAIDEN NAME: Martha Brangell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Mrs Edward F. Russell (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr

400.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cerebral Hemorrhage — 3 wks

DUE TO (c): Hypertension — yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 25 1959 to February 14 1959 that I last saw the deceased alive on 2 - 18 1959 and that death occurred at 7:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Oliver Purvis M.D. ADDRESS (Street, city or town, state): Annapolis Md DATE SIGNED: 2 - 19 - 59

PHYSICIAN'S NAME (Type): J. Oliver Purvis

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-20-59

22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff

22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: FEB 24 '59

24b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01421

1442

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 404 Myrtle Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: — Last: BROWN.

4. DATE OF DEATH: Month: 2 — Day: 13 — Year: 19 59

5. SEX: M

6. COLOR OR RACE: N

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/23/23

9. AGE (In years last birthday): 35 (35 yrs.)
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRUCK DRIVER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): U.S.A.

12. CITIZEN OF WHAT COUNTRY: Maryland

13. FATHER'S NAME: Jack BROWN

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): YES
(If yes, give war or dates of service): 1945

16. SOCIAL SECURITY NO:

17. INFORMANT: Records of Crownsville State Hospital — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarct.
DUE TO (b): Arteriosclerotic Heart Disease.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Alcoholism.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October, 19 58, to February, 19 59, that I last saw the deceased alive on 13th February, 19 59, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.

ADDRESS (Street, city or town, state): Crownsville State Hospital

DATE SIGNED:

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp

Crownsville Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-18-59

22c. NAME OF CEMETERY OR CREMATORY: Bates Funeral

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Adolphus Halstead Bruce — ADDRESS: 2182 Hillsdale

24a. REC'D BY REGISTRAR — DATE: FEB 16 '59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01422

CERTIFICATE OF DEATH

1412 Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel [redacted]LAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Odenton
d. STREET ADDRESS: Route # 1, Box 406-A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Jerry; Middle Lynn; Last Brown
4. DATE OF DEATH: Month February; Day 26; Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: February 25, 1959
9 AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours 12; Min. 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Clarence Gilmer Brown
14. MOTHER'S MAIDEN NAME: Carolyn Jeannette Ford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: Mother
Address: Rt. 1, Box 406A Odenton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): diffuse pulmonary atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
DUE TO
7604.5
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): prematurity — 12 hrs
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 25 Feb, 1959, to 26 Feb, 1959, that I last saw the deceased alive on 25 Feb, 1959, and that death occurred at 12:20 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James L Hudson, Jr. M.D.
ADDRESS (Street, city or town, state): RIVER CLUB ESTATES
DATE SIGNED: 27 Feb 59
PHYSICIAN'S NAME (Type): James I. Hudson, Jr. EDGEWATER MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/28/59
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial
22d. LOCATION (City, town, or county) (State): Glen Burnie,

23 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: James S. Kirkley Hopping and Kirkley, Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE MAR 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1443 Reg. Dist. No. 01423

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup
c. LENGTH OF STAY IN 1b 4 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maryland House of Correction Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md. b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 861 Lemon St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Joseph Middle A. Last Bryan

4. DATE OF DEATH Month Feb Day 27 Year 19 57

5. SEX M | 6. COLOR OR RACE C | 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Sep 25 1902

9. AGE (In years last birthday) 55 yrs. | IF UNDER 1 YEAR Months 5 Days | IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U S A

13 FATHER'S NAME Marvin Bryan
14. MOTHER'S MAIDEN NAME Gibbata Tolliver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-03-3083
17. INFORMANT Mary Bryan Address 861 Lemon St

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 5 days
DUE TO
(b) Hypertensive Vascular Disease
DUE TO
(c) Arteriosclerosis generalized

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 592 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-24, 19 57 to 2-27, 19 57 that I last saw the deceased alive on 2-27, 19 57, and that death occurred at 7:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE John M. Yosuico M.D. ADDRESS (Street, city or town, state) RFD #1 Jessup, Md DATE SIGNED 2-27-57

PHYSICIAN'S NAME (Type) Jose M. Yosuico R.F.D. # 1 Jessup, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3/3/57
22c. NAME OF CEMETERY OR CREMATORY Mt Auburn
22d. LOCATION (City, town, or county) Baltimore (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Charles Nicholson ADDRESS 1111 W. Baro St
24a. REC'D BY REGISTRAR DATE MAR 4 '57
24b. REGISTRAR'S SIGNATURE Clinton L. Adams

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS 15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1444 **CERTIFICATE OF DEATH** Reg. Dist. No. 01424

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater
c. LENGTH OF STAY IN 1b 75 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt 1 Box 284

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater
d. STREET ADDRESS Rt 1 Box 284
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Margaret Middle Elizabeth Last Bull
4. DATE OF DEATH Month Feb. Day 4, Year 1959
5. SEX female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2-11-1883
9. AGE (In years last birthday) 75 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY HOME
11. BIRTHPLACE (State or foreign country) Edgewater, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Vinton Nichols,
14. MOTHER'S MAIDEN NAME Alice Purdy,

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Albert T. Bull, Address Edgewater, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days

450X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic vasicular disease — 2 years

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1-30, 1959, to 2-3, 1959, that I last saw the deceased alive on 2-4, 1959, and that death occurred at 6:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Sylvia M Lim M.D. ADDRESS (Street, city or town, state) Rt 1 Box 277-M DATE SIGNED 2-4-59

PHYSICIAN'S NAME (Type) Sylvia M. Lim Edgewater, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Buried
22b. DATE THEREOF 2-7-59
22c. NAME OF CEMETERY OR CREMATORY Mayo Memorial Cem
22d. LOCATION (City, town, or county) Mayo (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons ADDRESS Annapolis Md
24a. REC'D BY REGISTRAR DATE FEB 6 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item b 1445 3-2-59 et

CERTIFICATE OF DEATH

1445

Reg. Dist. No. 01425

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21201-4
d. STREET ADDRESS 385 Bond St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First William Middle Caldwell Last
4. DATE OF DEATH Month 2 Day 27 Year 1959

5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3-16-72
9. AGE (In years last birthday) 86 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) —
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Obee Caldwell
14. MOTHER'S MAIDEN NAME Lucinda —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Charles Gans - Di 20857

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis Failing — INTERVAL BETWEEN ONSET AND DEATH —
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized Osteosclerosis — Years
DUE TO
(c) Vascular Seizure —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-14, 1959, to 2-21, 1959, that I last saw the deceased alive on 2-21, 1959, and that death occurred at 11:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Felix Feinberg M.D. ADDRESS (Street, city or town, state) P. Box 37 Edgewood Md. DATE SIGNED

PHYSICIAN'S NAME (Type) Felix Feinberg M.D. 2-22-59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Feb 26 59
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary
22d. LOCATION (City, town, or county) (State) A.A. County Md.

23. FUNERAL DIRECTOR'S SIGNATURE Milton E. Elliott ADDRESS 1129 N. Carrollton St
24a. REC'D BY REGISTRAR DATE FEB 25 '59
24b. REGISTRAR'S SIGNATURE Chas. E. Hall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Filed 2-24-59 et

1446

CERTIFICATE OF DEATH

01426

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A.A. Co — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD — b. COUNTY: AA Co

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel

c. LENGTH OF STAY IN 1b: 3 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Margarets Hospital

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: At home - St. Margarets

e. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Regina — Middle: — Last: Carroll

4. DATE OF DEATH: Month: 2 — Day: 10 — Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1874

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Not Employed

11. BIRTHPLACE (State or foreign country): Harford Co Md

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Richard Foley

14. MOTHER'S MAIDEN NAME: Lochary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): ✓

16 SOCIAL SECURITY NO.: ✓

17. INFORMANT: MR FRANK S HARNE Address: ANNAPOLIS RD2 Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)): myocardit: chronic — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO

422.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2-10, 1959, to 2-10, 1959, that I last saw the deceased alive on 2-10, 1959, and that death occurred at 12 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E Lunkenheimer M.D. — ADDRESS (Street, city or town, state): Chesapeake Ave — DATE SIGNED

PHYSICIAN'S NAME (Type): E. Lunkenheimer — Annapolis Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb 13/59

22c NAME OF CEMETERY OR CREMATORY: St Ignatius Hickory

22d. LOCATION (City, town, or county) (State): Hickory Harford Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph T Fritz — ADDRESS: Bel Air Md

24a. REC'D BY REGISTRAR DATE: FEB 13 59

24b. REGISTRAR'S SIGNATURE: Wilmer L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1447 **CERTIFICATE OF DEATH** 01427

Reg. Dist. No. 27

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft Meade
U.S.Army Hospital
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.Army Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkridge
d. STREET ADDRESS: Box 272
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First WILLIAM Middle JAMES Last CARLTON

4. DATE OF DEATH: Month February Day 5 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11 October 1958

9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR: Months 3 Days 24 IF UNDER 24 HRS.: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James E. Carlton

14. MOTHER'S MAIDEN NAME: Marie C. Greeno

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17 INFORMANT: James E. Carlton (father)
Address: Eldridge, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH:

571.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Electrolyte Imbalance — 5 days

DUE TO

(c) Diarrhea — 6 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that I attended the deceased from 2 February, 1959, to 5 February, 1959, that I last saw the deceased alive on 5 February, 1959, and that death occurred at 1000 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Roger C Moyer M.D.

ADDRESS (Street, city or town, state): U.S.Army Hospital, Ft Meade, Md

DATE SIGNED: 5 Feb 59

PHYSICIAN'S NAME (Type): ROGER C. MOYER, CAPT, MC.

U. S. ARMY HOSPITAL, FT MEADE, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2-10-59

22c NAME OF CEMETERY OR CREMATORY: Baltimore National

22d. LOCATION (City, town, or county) (State): Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: William Cook, Inc., 1217 St. Paul Street

24a. REC'D BY REGISTRAR DATE: FEB 9 '59

24b. REGISTRAR'S SIGNATURE: Miriam

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2050513.xv6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Filmed 39 2-20-59 et

1448

CERTIFICATE OF DEATH

Reg. Dist. No. 01428

1. PLACE OF DEATH
a. COUNTY: Anne Arundel. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville.
c. LENGTH OF STAY IN 1b: 6 days.
d. NAME OF HOSPITAL (If not in hospital, give street address or INSTITUTION): Crownsville State Hospital.

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Highland Park
d. STREET ADDRESS: 1209 — 69th Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Henrietta Middle: Last: CLARK
4. DATE OF DEATH: Month: 2 Day: 13 Year: 1959
5. SEX: F
6. COLOR OR RACE: N
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/3/1908
9. AGE (In years last birthday): 50 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Richard Barnes
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Elizabeth Clark — Daughter, Highland Park. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hyperpyrexia — INTERVAL BETWEEN ONSET AND DEATH
44^x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebro-vascular-accident — Brain Stem.
DUE TO (c): Hypertensive Cardiovascular Renal Disease.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anemia — moderate.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/9/59 to 2/13/59, that I last saw the deceased alive on 2/13/59, and that death occurred at 9:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D
ADDRESS (Street, City or town, state): Crownsville State Hospital / Crownsville. Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type): Lionel McHenry Mapp

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/18/59
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn.
22d. LOCATION (City, town, or county) (State): Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John L. Stewart — 30 — Hyatts
24a. REC'D BY REGISTRAR DATE: FEB 17 '59
24b. REGISTRAR'S SIGNATURE: Catherine L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1449 — 01429 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riviera Manor
c. LENGTH OF STAY IN 1b
d. NAME OF HOSP.TAL (If not in hospital, give street address) OR INSTITUTION: Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): South Berwick
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: James; Middle: Edward; Last: Coer
4. DATE OF DEATH: Month: Feb. Day: 12 Year: 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug 31, 1875
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Waterbury Conn
12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: James Edward Coer
14. MOTHER'S MAIDEN NAME: Ellen C. McCann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO
17. INFORMANT: Address: Son Mallon E. Coer

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH
159X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hemorrhoid Carcinomatosis
DUE TO (c): Carcinoma Sigmoid, C.V. Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 1958, to 2-12-59, that I last saw the deceased alive on 2-11-59, 19, and that death occurred at 5:30 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: Robert R. Hahn M.D.
ADDRESS (Street, city or town, state): Severna Park Md
DATE SIGNED: 2-12-59.
PHYSICIAN'S NAME (Type): Robert R. Hahn

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-16-59
22c. NAME OF CEMETERY OR CREMATORY: Pine Hill
22d. LOCATION (City, town, or county) (State): South Berwick Conn
23. FUNERAL DIRECTOR'S SIGNATURE: John F. Hoppington
ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: FEB 16 '59
24b. REGISTRAR'S SIGNATURE: C. M. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1413 **CERTIFICATE OF DEATH** 01430

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Edgewater Beach
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater Beach
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lillian Middle: L. Last: CORNWELL

4. DATE OF DEATH: Month: Feb. Day: 6 Year: 1959

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 7/11/73

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John B. Davis

14. MOTHER'S MAIDEN NAME: Cecil R. Hickson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Fred C. Cornwell-9014 Fairview Rd. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO (b): arteriosclerotic coronary heart disease — 16 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): general arteriosclerosis pulmonary edema.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-6 19 59 to 2-6 19 59 that I last saw the deceased alive on 2-5 19 59, and that death occurred at 4:40 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edith Roeller M.D. — ADDRESS (Street, city or town, state): 45 FRANKLIN ST ANNAPOLIS MD — DATE SIGNED: 2-6-59

PHYSICIAN'S NAME (Type): EDITH ROELER MD — Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/9/59

22c. NAME OF CEMETERY OR CREMATORY: Congressional Cemetery

22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co. — ADDRESS: Washington D. C.

24a. RECD BY REGISTRAR DATE: FEB 10 59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1450 — 01431 — Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2yr.4mo.24days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 129 Amity Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bud — Middle: — Last: Davis

4. DATE OF DEATH: Month: 2 — Day: 18 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December, 1883

9. AGE (In years last birthday): 75 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Longshoreman

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Davis

14 MOTHER'S MAIDEN NAME: Hallie

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16 SOCIAL SECURITY NO.: 217-01-0735

17 INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct
DUE TO
(b): Arteriosclerotic Cardiovascular-Renal Disease
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Tuberculosis, Pulmonary-far advanced

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Hour: ------ a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State): ----------

21. I certify that I attended the deceased from 9/24, 19 56 to 2/18, 19 59, that I last saw the deceased alive on 2/18, 1959, and that death occurred at 6:30A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp. M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, M.D.
DATE SIGNED: 2/18/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.
Crownsville State Hospital, M. D. 2/18/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 23 1959
22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
22d. LOCATION (City, town, or county) (State): Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Mrs Katie R Williams
ADDRESS: 322 N. Schroeder St

24a REC'D BY REGISTRAR DATE: FEB 19 '59
24b REGISTRAR'S SIGNATURE: C. [illegible] Mudd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event with n 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01432

CERTIFICATE OF DEATH

1414 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Davidsonville
d. STREET ADDRESS: Route 1, Box 30A
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: James — Middle: Edward — Last: DAVIS

4. DATE OF DEATH: Month: February — Day: 18 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 18 February 1959

9. AGE (In years last birthday): yrs

IF UNDER 1 YEAR: Months: — Days: — Hours: 4 — Min.: 13
IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - -

10b. KIND OF BUSINESS OR INDUSTRY: - - -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Sperry David DAVIS

14. MOTHER'S MAIDEN NAME: Rosetta Lucile ROLLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: U.S. Naval Hospital, Annapolis, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): HYALINE MEMBRANE DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 1 Hour

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 18 February, 19 59, to 18 February, 19 59, that I last saw the deceased alive on 18 February, 19 59, and that death occurred at 2:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: _____ M.D. — ADDRESS (Street, city or town, state): U.S. NAVAL HOSPITAL — DATE SIGNED: 2-19-59

PHYSICIAN'S NAME (Type): F. M. KENNY LT MC USNR — ANNAPOLIS, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-20-59

22c. NAME OF CEMETERY OR CREMATORY: Naval Cemetery

22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Hopping Funeral Home Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: FEB 24 '59

24b. REGISTRAR'S SIGNATURE: C. Mac S. Hearn

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01433

1415

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.N.Hospital, Annapolis, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 163 Prince George Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Agostino — Middle: (n) — Last: DiMAGGIO

4. DATE OF DEATH: Month: Feb — Day: 23 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-16-78

9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S.Navy

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Navy

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Gregory DiMAGGIO

14. MOTHER'S MAIDEN NAME: Elizabeth NELLI

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: U.S.Naval Hospital Annapolis, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 21 Hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertension
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-23, 1959, to 2-23, 1959, that I last saw the deceased alive on 2-23, 1959, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R.J. Burns for M.D. — ADDRESS (Street, city or town, state): U.S.Naval Hospital, Anna.Md. — DATE SIGNED: 2-24-59

PHYSICIAN'S NAME (Type): R. J. BURNS, LT. C USN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 2-26-59 — 22c. NAME OF CEMETERY OR CREMATORY: St. Mary's — 22d. LOCATION (City, town, or county): Annapolis (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR — DATE: FEB 26 '59 — 24b. REGISTRAR'S SIGNATURE: C. [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1451 — Reg. Dist. No. 01434

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
c. LENGTH OF STAY IN 1b: 6 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Taylor Mem. Inf.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Same
d. STREET ADDRESS: R.F.D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mrs. Middle: Ruby Edith Last: Drgott

4. DATE OF DEATH: Month: February Day: 6th Year: 19 59

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/2/92
9. AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Tamaqua Penn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Johnathon Miller
14. MOTHER'S MAIDEN NAME: Marguerite Tork

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs. Sara Johnson (Daughter)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive cardio vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 3 y.
443 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 7th, 1955, to Feb. 1, 1959, that I last saw the deceased alive on 2/6/59, 19, and that death occurred at 7.30 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Gustave H. Paulet M.D. — ADDRESS (Street, city or town, state): Glen Burnie, Md. — DATE SIGNED: 2/7/59

PHYSICIAN'S NAME (Type): Gustave H. Paulet, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/9/59
22c. NAME OF CEMETERY OR CREMATORY: Jersey Shore Cemetery
22d. LOCATION (City, town, or county) (State): Lycoming Co., Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Thomas H. Kirkley — ADDRESS: Hopping & Kirkley, Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE: FEB 9 '59
24b. REGISTRAR'S SIGNATURE: C. Elmer Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1452 CERTIFICATE OF DEATH

Reg. Dist. No. 01435

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
c. LENGTH OF STAY IN 1b: 51 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
d STREET ADDRESS: Rt 1 Box
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles Middle Franklin Last Evans

4. DATE OF DEATH: Month 2 Day 7 Year 1959

5. SEX: Male

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: July 5th 1873

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman & Carpenter

10b KIND OF BUSINESS OR INDUSTRY: (Retired)

11. BIRTHPLACE (State or foreign country): Riva, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles W. Evans,

14 MOTHER'S MAIDEN NAME: Madora (Harden Name ?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16 SOCIAL SECURITY NO.: 212-18-8710

17 INFORMANT: George H. Evans, Address: Edgewater, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic cardio-vasicular disease — 3 years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-26, 1958 to 2-6, 1959 that I last saw the deceased alive on 2-7, 1959, and that death occurred at 3:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Sylvia M. Lim M.D. ADDRESS (Street, city or town, state): RFD # 1 Box 219-M DATE SIGNED: 2-7-59

PHYSICIAN'S NAME (Type): Sylvia M. Lim Edgewater, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Feb 9, 1959
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial
22d LOCATION (City, town, or county) (State): Annapolis, Md

23. FUNERAL DIRECTOR'S SIGNATURE: T A Hardesty & Son ADDRESS: Galesville, Md

24a. REC'D BY REGISTRAR DATE: FEB 11 '59
24b REGISTRAR'S SIGNATURE: C[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1453

CERTIFICATE OF DEATH

01436

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 6mo. 4days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1400 E. Fairmount Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jonn; Middle: ; Last: Evans

4. DATE OF DEATH: Month: 2/; Day: 12; Year: 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5/10/81

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months ; Days ; IF UNDER 24 HRS: Hours ; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-03-1686

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Syphilitic & Arteriosclerotic Cardiovascular
023X
DUE TO: Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Month, Day, Year, Hour ---, p m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----------

20f. (City or town) (County) (State): ----------

21. I certify that I attended the deceased from 8/8, 1958, to 2/12, 1959, that I last saw the deceased alive on 2/12, 1959, and that death occurred at 4:55A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M D

ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.

DATE SIGNED: 2/13/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

Crownsville State Hospital, Md. 2/13/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 2/13/59

22c. NAME OF CEMETERY OR CREMATORY: University of Md

22d. LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese

ADDRESS: 163 Washington St

24a. REC'D BY REGISTRAR DATE: FEB 16 59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1454 **CERTIFICATE OF DEATH** 01437

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park
d. STREET ADDRESS Rt 1 Box 344 S
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Glenn Middle John Last Sollers

4. DATE OF DEATH Month Feb. Day 26 Year 1959

5. SEX M. 6. COLOR OR RACE C. 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH 2/4/1879 9. AGE (In years last birthday) 79 yrs

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Boston Mass.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Neil Glenn?
14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO no
17. INFORMANT Address Johnson Glenn Jr. Severna Pk. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO (b) Hypertensive C.V. disease
DUE TO (c) Generalized arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 5 19__ to Feb 26 19__ that I last saw the deceased alive on Feb 22 59 19__ and that death occurred at 5 A M, from the causes and on the date stated above

ACTUAL SIGNATURE Robert B. Hall M.D. ADDRESS (Street, city or town, state) Severna Park DATE SIGNED Feb 26 59

PHYSICIAN'S NAME (Type) Robert B. Hall

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF 3-1-59
22c. NAME OF CEMETERY OR CREMATORY Town Neck
22d. LOCATION (City, town, or county) (State) Galesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. ADDRESS Owings, Md.

24a. REC'D BY REGISTRAR DATE MAR 3 '59
24b REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1455

Reg. Dist. No. 01438

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park — c. LENGTH OF STAY IN 1b: 2 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Linstead on the Severn	d. STREET ADDRESS: Linstead on the Severn — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
MARGARET	LOUISE	GOSNELL	FEBRUARY	13,	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
Female	White		June 29, 1882	76 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Hostess (Ret.)	Johns Hopkins	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles A. Gosnell	Tamsey R. Horan

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT Address
no		Mr. Charles M. Gosnell, Same As #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

722.0

DUE TO (b) Rheumatoid Arthritis — 20 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from ///, 1940 to Feb. 13, 1959, that I last saw the deceased alive on Feb. 13, 1959, and that death occurred at 8:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE James S. Billingslea M.D — ADDRESS (Street, city or town, state): 103 Central Ave., N.W. — DATE SIGNED: 2/14/59

PHYSICIAN'S NAME (Type) James S. Billingslea — Glen Burnie, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Feb. 16/59	Loudon Park Cem.	Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b REGISTRAR'S SIGNATURE
Richard V. Singleton, Glen Burnie, Md.	FEB 19 '59	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01439

1416

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Del.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wilmington
d. STREET ADDRESS: 64 Highland Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HOWARD — Middle ROBERT — Last GRAY — SR

4. DATE OF DEATH: Month February — Day 28 — Year 19 59

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 12, 1898
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Manf. Co.
11. BIRTHPLACE (State or foreign country): Del.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unk own
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mr. H.M. Gray Jr. - Son — Address: 558 Congress Ave. Havre De Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute intracerebral hemorrhage
331X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 12 hr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12 P.M. 2/19 19 59, to 4 P.M. 2/24 19 59, that I last saw the deceased alive on 2/19 19 59, and that death occurred at 11 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John E. Hedeman M.D. ADDRESS (Street, city or town, state): 121 Carroll DATE SIGNED: 2/24/59
PHYSICIAN'S NAME (Type): John Hedeman MD Carroll, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 23, 1959
22c. NAME OF CEMETERY OR CREMATORY: Grace Lawn Mem. Park Silverbrook Cemetery
22d. LOCATION (City, town, or county) (State): Farnhurst Wilmington, Del.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: HOPPING FUNERAL HOME Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: FEB 24 '59
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01440

CERTIFICATE OF DEATH

1456

Reg. Dist. No. 27

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft George G. Meade
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.Army Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
d. STREET ADDRESS: Box 222
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CRAIG — Middle Renard — Last GRIFFIN

4. DATE OF DEATH: Month February — Day 25 — Year 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 29 November 1958

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months 2 Days 26 — IF UNDER 24 HRS Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John R. Griffin

14. MOTHER'S MAIDEN NAME: Geraldine M. Snipes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Hospital Records — Address: U.S. Army Hosp, Ft Meade, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumothorax — INTERVAL BETWEEN ONSET AND DEATH: ½ day

493X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Pneumonia — 3 days

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 24 Feb, 1959, to 25 Feb, 1959, that I last saw the deceased alive on 25 Feb, 1959, and that death occurred at 4:53P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Fred W Laffrey MD — ADDRESS (Street, city or town, state): U.S.Army Hospital, Ft Meade, Md — DATE SIGNED: 25 Feb 59

PHYSICIAN'S NAME (Type): FRED W. LAFFREY, CAPT, MC — U.S.Army Hospital, Ft Meade, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar.1,1959

22c. NAME OF CEMETERY OR CREMATORY: Carver Memorial Park

22d LOCATION (City, town, or county) (State): Prince George County;Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: ELROY O.WILSON FUNERAL HOME 1000 Brantley Ave.

24a. REC'D BY REGISTRAR DATE: MAR 6 '59

24b REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1417

01441 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS - Box 1048
d. STREET ADDRESS: Rt. 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: CALVIN — Middle: GROSS — Last: CALVERT — ALIAS
4. DATE OF DEATH: Month: 2 — Day: 23 — Year: 1959

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MAY 9 - 1902
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): A. A. Co. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Gross
14. MOTHER'S MAIDEN NAME: Mary P. Miles

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W.I
16. SOCIAL SECURITY NO.:
INFORMANT: Mary-Priscilla Brashears — Address: Rt. 3-Box Anna. Md. 1048

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Arterial Hypertensive Cardio Vascular
DUE TO (c): Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4 45x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: a. m. / p. m. Month: Day: Year: 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1958, to Feb 24, 1959 that I last saw the deceased alive on Feb 24, 1959, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D.: R. L. Richardson — ADDRESS (Street, city or town, state): 110 CLAY ST ANNAPOLIS MD — DATE SIGNED: 2/25/59
PHYSICIAN'S NAME (Type): R. L. Richardson 110 Clay St. Anna. Md.

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b DATE THEREOF: 2-26-59
22c. NAME OF CEMETERY OR CREMATORY: ANNAPOLIS - NECK
22d. LOCATION (City, town, or county): ANNAPOLIS - Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Hicks III — ADDRESS: ANNAPOLIS - Md.
24a REC'D BY REGISTRAR DATE: MAR 2 '59
24b. REGISTRAR'S SIGNATURE: Charles S. Kinna

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1457

02625

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 0mo 20days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore? 3 Vol-4
d. STREET ADDRESS: Unknown?
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First John — Middle — Last Gwaltney

4. DATE OF DEATH: Month 2 — Day 27 — Year 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 1, 1918

9. AGE (In years last birthday): 40 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Thomas Gwaltney

14. MOTHER'S MAIDEN NAME: Otelia

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cachexia
150X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cancer of Esophagus
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Abscess of Brain

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------

20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. ----- 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ------

20f. (City or town) (County) (State): ---------

21. I certify that I attended the deceased from 8/7, 1958, to 2/27, 1959, that I last saw the deceased alive on 2/27, 1959, and that death occurred at 8:50A. M, from the causes and on the date stated above

ACTUAL SIGNATURE: [signature] M.D
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 2/27/59

PHYSICIAN'S NAME (Type): L. Benedict, M. D.
Crownsville State Hospital, Md. 2/27/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-10-59
22c NAME OF CEMETERY OR CREMATORY: Hospital Grounds
22d. LOCATION (City, town, or county) (State): Crownsville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] M.D.
ADDRESS:

24a. REC'D BY REGISTRAR DATE: MAR 13 '59
24b REGISTRAR'S SIGNATURE: Cortland S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 3 and 2 and 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1418 **CERTIFICATE OF DEATH**

01442
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis,
c. LENGTH OF STAY IN 1b: 30 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 96 Duke of Gloucester St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Aloysius — Last: Haley Sr.

4. DATE OF DEATH: Month: February — Day: 28 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 14, 1870

9. AGE (In years last birthday): 88 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Roofing Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Roofing Contractor

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: James (n) Haley

14 MOTHER'S MAIDEN NAME: Sebina McManus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1898-1899

16. SOCIAL SECURITY NO.: 220-05-0496

17. INFORMANT — Address: James A. Haley Jr. 96 Duke of Gloucester St.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Heart Disease
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 28 Feb. 19 59, to 28 Feb., 19 59, that I last saw the deceased alive on 28 Feb. 1959, and that death occurred at 1025 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: M. J. Miller M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital, Annapolis, Maryland — DATE SIGNED

PHYSICIAN'S NAME (Type): M. J. MILLER LT (MC) USNR

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3-4-59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county): Arlington (State): VA.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: MAR 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1458

01443

Reg. Dist. No. 27

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft George G. Meade, Md

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Severna Park

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: U. S. Army Hospital

d STREET ADDRESS: 17 Admiral Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Maude — Middle: C (Norman) — Last: Hanks

4. DATE OF DEATH: Month: February — Day: 6 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 4, 1878

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: William E. Norman

14. MOTHER'S MAIDEN NAME: (Unknown) Corker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Col. Cecil Corbin, 17 Admiral Rd, Severna Park, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 weeks

DUE TO

(b): Cerebral arteriosclerosis — Unknown

DUE TO

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 15 Jan, 1958, to 6 Feb, 1959, that I last saw the deceased alive on 6 February, 1959, and that death occurred at 1000 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: George B. Hagan, Capt, M.C. M.D. — ADDRESS (Street, city or town, state): U.S. Army Hospital, Ft George G. Meade, Md. — DATE SIGNED: 6 Feb 59

PHYSICIAN'S NAME (Type): GEORGE B. HAGAN, CAPT., MC — U. S. Army Hospital, Ft George G. Meade, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b DATE THEREOF: 2/7/59

22c. NAME OF CEMETERY OR CREMATORY: Greenwood Cem.

22d. LOCATION (City, town, or county) (State): Ft. Worth, Texas

23 FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tiekner & Sons - Baltimore, Md — ADDRESS:

24a. REC'D BY REGISTRAR DATE: FEB 9 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

CERTIFICATE OF DEATH

1419 — 01444 — Reg. Dist. No

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Annapolis
d. STREET ADDRESS: Rt. 1 Box 15
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: AGNES — Middle: V — Last: HARDESTY

4. DATE OF DEATH: Month: FEBRUARY — Day: 8 — Year: 19 59

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		Aug. 19, 1900	58 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife	own home	Maryland	USA

13. FATHER'S NAME: Anton Steiner

14 MOTHER'S MAIDEN NAME: Annie Harold

15 WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address
no	no	none	Mrs Joseph Mayr-Daughter- same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Uremia & Anemia	3 wks.
DUE TO (b)	Hemmal-Stud Wilson Dis	1 Yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)	Diabetes	10 Yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): cystitis, surgically absent, kidney

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2-6-59 to 2-8-59, that I last saw the deceased alive on 2-8-59, and that death occurred at 9 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank Shipley M.D — ADDRESS (Street, city or town, state): 124 Carthedral St — DATE SIGNED: 2-10-59

PHYSICIAN'S NAME (Type): Frank Shipley MD — Annapolis, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
Burial	Feb. 11, 1959	All Hallows Cemetery	Davidsonville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME — ADDRESS: Annapolis, Maryland

24a. REC'D BY REGISTRAR: DATE FEB 13 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1459 **CERTIFICATE OF DEATH** 01445

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and the nearest town): St Margarets
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Log Inn ROAD

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St Margarets
d. STREET ADDRESS: R F D
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Maysie Middle: C Last: Hays

4. DATE OF DEATH: Month: 2 Day: 5 Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 30-1893

9. AGE (In years last birthday): 65 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Sparrows Pt. Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Frank Kirk

14. MOTHER'S MAIDEN NAME: Sophie Guenther

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Oscar S. Hays Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): arteriosclerotic cardiovascular disease
DUE TO (b): hypertension
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 15 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1940, to Dec 5, 1959, that I last saw the deceased alive on Dec 4, 1959, and that death occurred at 1-15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: S Bornsuck M.D. ADDRESS (Street, city or town, state): Anne Gannon Blvd DATE SIGNED: 2/2/59

PHYSICIAN'S NAME (Type): S BORNSUCK Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-8-59

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial

22d. LOCATION (City, town, or county): Glen Burnie (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Layla Sons ADDRESS: Annapolis Md.

24a. RECD BY REGISTRAR DATE: FEB 9 59

24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01446

1460

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY: Anne Arundel	MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park	c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Arleigh Heights Ld.	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md.	b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Same	
d. STREET ADDRESS: Same	e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First Garrett Middle Welch Last Peterson	4. DATE OF DEATH: Month February Day 12th Year 1959
5. SEX: M	6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 1/4/54
9. AGE (In years last birthday): 5 yrs.	IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None	10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Arleigh Heights, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Irvand Jensen	14. MOTHER'S MAIDEN NAME: Grace Jensen Irvins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO: None
17. INFORMANT Address: Grace Jensen (Mother)	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Charred glove recognition — INTERVAL BETWEEN ONSET AND DEATH: Sudden

916.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): was involved in auto accident on fire. second floor.

20c. TIME OF INJURY Hour	Month, Day, Year	20d. INJURY OCCURRED	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
2.40 a.m. p.m.	2/12/59 19	While at work ☒ Not while at work ☐	Home	Severna Park Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert M.D. M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 2/24/59

EXAMINER'S NAME (Type): Gustave H. Faubert M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
Burial	2-15-59	First Baptist Cem.	Earleigh Hghts., Md.

23 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
J. B. Johnson	Annapolis Md.	FEB 17 '59	[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1463 — 01447 — Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 13yr.6m 1da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: ?
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: E. — Last: Hill

4. DATE OF DEATH: Month: 2 — Day: 10 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1907

9. AGE (In years last birthday): 52+ yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH:
434.3
DUE TO (b): Constrictive Pericarditis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): ---

20c. TIME OF INJURY: Month, Day, Year; Hour a.m. / p.m. ---- 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---

20f. (City or town) (County) (State): ---

21. I certify that I attended the deceased from 8/9 19 45 to 2/10 19 59 that I last saw the deceased alive on 2/10 19 59, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 2/10/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.
Crownsville State Hospital, Md. 2/10/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 14-59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.
22d. LOCATION (City, town, or county) (State): Anne Arundel Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph A. Locke Jr.
ADDRESS: 1304 N Central Ave.

24a. REC'D BY REGISTRAR DATE: FEB ' 59
24b. REGISTRAR'S SIGNATURE: Elmer S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01448

1462

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIVA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MANOR Guest House

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Conn. — b. COUNTY: Middlesex Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Middletown 45 x -
d. STREET ADDRESS: High St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle C. — Last HILL

4. DATE OF DEATH: Month February — Day 4 — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 22 - 1880

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Conn

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Abraham Crosley

14. MOTHER'S MAIDEN NAME: Minnie Footitt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Joseph Crosley — Address: King Geo St Annapolis Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO (b): Arteriosclerotic Cardiovascular

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Nerves — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/3, 19 59, to 2/4, 19 59, that I last saw the deceased alive on 2/3, 19 59, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard N. Peeler M.D. — ADDRESS (Street, city or town, state): 120 CATHEDRAL ST — DATE SIGNED: 2/4/59

PHYSICIAN'S NAME (Type): RICHARD N. PEELER — ANNAPOLIS, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-7-59

22c. NAME OF CEMETERY OR CREMATORY: St John Cemetery

22d. LOCATION (City, town, or county) (State): Middletown Conn

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Taylor Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: FEB 6 '59

24b. REGISTRAR'S SIGNATURE: C. Irvin S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01449

1463

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admiss'on) a STATE: Maryland b COUNTY: Baltimore
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville — c. LENGTH OF STAY IN 1b: 17 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital	d. STREET ADDRESS: 820 George Street — e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Nathaniel		Jones	2	14	19 59

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Male	Negro		1885	73 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Unknown	-------	Unknown	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Unknown	Unknown	Hospital Records

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Terminal Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH:

023X

DUE TO (b): Syphilitic Cardiovascular Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of Stomach

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
------- 19		----------	----------

21 I certify that I attended the deceased from 1/27, 19 59, to 2/14, 19 59, that I last saw the deceased alive on 2/14, 19 59, and that death occurred at 10:45A.M. from the causes and on the date stated above

ACTUAL SIGNATURE	ADDRESS (Street, city or town, state)	DATE SIGNED
Lionel McHenry Mapp M.D	Crownsville State Hospital, Md.	2/16/59
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.	Crownsville State Hospital, Md.	2/16/59

22a BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
Burial	2-18-59	Hosp. Grounds	Crownsville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Crownsville, Md.	FEB 26 '59	Cutting S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01450
Reg. Dist. No.

1464

1 PLACE OF DEATH a. COUNTY: Anne Arundel — WATER OAK POINT - PASADENA MARYLAND

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE: MD. b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X PASADENA -- MD.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

d STREET ADDRESS: /

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First THOMAS Middle J Last KANE

4. DATE OF DEATH: Month FEB. Day 14 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 6-30-1891

9. AGE (In years last birthday): 67 yrs

IF UNDER 1 YEAR: Months 8 Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET.

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): BALTIMORE

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: THOMAS

14. MOTHER'S MAIDEN NAME: MAGGIE HETCHEIN

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17 INFORMANT Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 2 days

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) CORONARY SCLEROSIS — 5 years

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 5/19, 1958 to 2/14, 1959 that I last saw the deceased alive on 2/11, 1959, and that death occurred at 6:20 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Brady Smith M.D — ADDRESS (Street, city or town, state): Riviera Beach — DATE SIGNED: 2/16/59

PHYSICIAN'S NAME (Type): J. BRADY SMITH — Pasadena Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-19-59

22c NAME OF CEMETERY OR CREMATORY: HOLY ROSARY

22d LOCATION (City, town, or county) (State): BALTIMORE MD

23 FUNERAL DIRECTOR'S SIGNATURE: Fred W. Ozgowski — ADDRESS: 1930 Eastern Ave

24a REC'D BY REGISTRAR DATE: FEB 17 '59

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01451
Reg. Dist. No.

1420

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 9 hours

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A. A. Gen. Hospital

3. NAME OF DECEASED (Type or print): First: Katherine — Middle: — Last: Kapp

4. DATE OF DEATH: Month: 2 — Day: 20 — Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 6-21-88

9. AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Catonsville

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Kroner

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): none (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Son in law. Address: Catonsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Extensive burn, 2nd. 3rd degree entire body — INTERVAL BETWEEN ONSET AND DEATH: 9 hours

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 916.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Burned in house fire

20c. TIME OF INJURY: Hour: 1 p.m. — Month, Day, Year: 2-20-59

20d. INJURY OCCURRED: While at work [ ] Not while at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Millersville (County): A A (State):

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Elmer Linhardt M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [ ]

DATE SIGNED: 2-20-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/23/59

22c. NAME OF CEMETERY OR CREMATORY: Severn Cemetery

22d. LOCATION (City, town, or county): Crownsville (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: [illegible]

24a. REC'D BY REGISTRAR DATE: FEB 25 '59

24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1465

CERTIFICATE OF DEATH

D1452
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits: write RURAL and give nearest town): Deale
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Md.
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Neal
d. STREET ADDRESS: Neal Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George Middle I. Last Kent

4. DATE OF DEATH: Month Feb Day 11 Year 19.59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 27, 1882
9. AGE (In years last birthday) 77 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Gen. Contractor
11. BIRTHPLACE (State or foreign country): Forest Co. Pa.
12. CITIZEN OF WHAT COUNTRY: U. S.

13. FATHER'S NAME: Benjamin F. Kent
14. MOTHER'S MAIDEN NAME: Letitia Maley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 223-28-3792
17. INFORMANT'S Address: Mrs. William Carter, 7208-13th Place Takoma Park Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized Arteriosclerosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 8 yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1958 to 11 Feb 1959, that I last saw the deceased alive on 11 Feb 1959, and that death occurred at 12:30 M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R B Sasscer M.D.
ADDRESS (Street, city or town, state): Upper Marlboro Md
DATE SIGNED: 11-2-59.

PHYSICIAN'S NAME (Type) R. B. Sasscer, M. D. Upper Marlboro, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/14/59
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Church Cem.
22d LOCATION (City, town, or county) (State): Reme Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ritchie Bros. Upper Marlboro, Md.
24a REC'D BY REGISTRAR DATE: FEB 17 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01453

1466

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2mo. 18 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 613 Cornell Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Julian — Middle — Last King

4. DATE OF DEATH: Month 2 — Day 15 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1900

9. AGE (In years last birthday): 58 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John King

14. MOTHER'S MAIDEN NAME: Mary Bean

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cor Pulmonale
DUE TO
(b): Asthma with Chronic Bronchitis
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Hour — a. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----------

20f. (City or town) (County) (State): -------

21. I certify that I attended the deceased from 11/21/58, to 2/15/59, that I last saw the deceased alive on 2/15/59, and that death occurred at 5:10 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 2/16/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.
Crownsville State Hospital, Md. 2/16/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-20-59
22c. NAME OF CEMETERY OR CREMATORY: Hosp. Grounds
22d. LOCATION (City, town, or county) (State): Crownsville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Wagner Funeral Home
ADDRESS: Crownsville, Md.

24a. REC'D BY REGISTRAR DATE: FEB 26 '59
24b. REGISTRAR'S SIGNATURE: Mrs. S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01454

1421 Reg. Dist. No.

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH
a COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: Maryland — b COUNTY: Anne Arundel
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d STREET ADDRESS: 915 Tyler Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT — Middle KLYMAN — Last
4. DATE OF DEATH: Month February — Day 19 — Year 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov 7, 1898
9. AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Forman- Const.
10b KIND OF BUSINESS OR INDUSTRY: General Const.
11 BIRTHPLACE (State or foreign country): New York
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Klyman
14. MOTHER'S MAIDEN NAME: Gussie (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16 SOCIAL SECURITY NO: unknown.
17. INFORMANT Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac — INTERVAL BETWEEN ONSET AND DEATH: sudden
434.4
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Natural causes
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: Feb. 19 19 59
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Annapolis (County) A.A. (State) Maryland

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: E. Linhardt, M D
EXAMINER'S NAME (Type): Elmer G. Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: February 19, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 20, 1959
22c. NAME OF CEMETERY OR CREMATORY: Kneseth Israel Cemetery
22d LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Hopping Funeral Home Annapolis, Maryland
24a. REC'D BY REGISTRAR DATE: FEB 24 '59
24b. REGISTRAR'S SIGNATURE: Elmer L. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
$M 2/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be recorded in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1467 — 01455 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
c. LENGTH OF STAY IN Tb:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Box 43 Pinewiff Beach

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Edgewater
d. STREET ADDRESS: Box 43 Rt 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK Middle L Last LANE
4. DATE OF DEATH: Month FEBRUARY Day 13, Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 14, 1899
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Printer's helper
10b. KIND OF BUSINESS OR INDUSTRY: Printing shop
11. BIRTHPLACE (State or foreign country): Scranton, Pa.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Frank Lane
14. MOTHER'S MAIDEN NAME: Sarah Hiller
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1-1921 to 9-1921
16. SOCIAL SECURITY NO.: 577 14 0113
17. INFORMANT: Mrs. Alice I. Lane Wife Address 905 Erie Ave. Takoma Park, 12, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac — INTERVAL BETWEEN ONSET AND DEATH: sudden
002 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Old Pulmonary T B C — 38 yrs
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Natural causes
20c. TIME OF INJURY: Month, Day, Year: Hour XX M. Feb. 14, 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Edgewater, A.A. Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Noturol causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED
EXAMINER'S NAME (Type): Elmer G. Linhardt — February 14, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 17, 1959
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemet
22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: HOPPING FUNERAL HOME Annapolis, Maryland
24a. REC'D BY REGISTRAR: DATE FEB 18 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Hearn

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1422

01456 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 PLACE OF DEATH
a COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: AA General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b COUNTY: AA
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 26 (Rural)
d. STREET ADDRESS: 460 Carvel Beach Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: Harold — Last: Lehtma
4. DATE OF DEATH: Month: Feb. — Day: 5 — Year: 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 2,1958
9. AGE (In years last birthday) yrs.: 9
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: *********
11 BIRTHPLACE (State or foreign country): Annapolis, Md.
12 CITIZEN OF WHAT COUNTRY?: USA

13 FATHER'S NAME: Harold Lehtma
14. MOTHER'S MAIDEN NAME: Carol Owen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service): ********
16 SOCIAL SECURITY NO.: *********
17. INFORMANT — Address: Mrs Harold Lehtma, Same as 2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Dehydration, Circulatory collaps — INTERVAL BETWEEN ONSET AND DEATH: 3 hours
DUE TO (b): Profuse diarrhea, gastro enteritis — 2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2-4, 19 59, to 2-5, 19 59, that I last saw the deceased alive on 2-5, 19 59, and that death occurred at 9 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Otto Vogel MD, MD — ADDRESS (Street, city or town, state): 403 N. RITCHIE H. — DATE SIGNED: 2-7-59
PHYSICIAN'S NAME (Type): OTTO VOFEL, MD — GLEN BURNIE, Md

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/7/59
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial
22d. LOCATION (City, town, or county) (State): Glen Burnie, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Dennis J. Kirkley — ADDRESS: Hopping and Kirkley, Glen Burnie, Md.
24a REC'D BY REGISTRAR DATE: FEB 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01457

Reg. Dist. No. 1468

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
c. LENGTH OF STAY IN 1b 10 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION Plaza Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Freetown Glen Burnie
d. STREET ADDRESS Box 326 Rt 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Arthur Middle Macey Last
4. DATE OF DEATH Month 2 Day 16 Year 1959
5. SEX M.
6. COLOR OR RACE C
7. MARRIED ✓ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12-12-1910
9. AGE (In years last birthday) 48 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) —
12. CITIZEN OF WHAT COUNTRY? —

13. FATHER'S NAME —
14. MOTHER'S MAIDEN NAME —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Bernice Macey Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Cerebral Vascular Accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hypertensive Sclerotic Cardiovascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) —
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 —
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f (City or town) (County) (State) —

21. I certify that I attended the deceased from 2-6, 19 59 to 2-16, 19 59, that I last saw the deceased alive on 2-16, 19 59, and that death occurred at 10:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D. Felix Grundy
ADDRESS (Street) city or town, state) P. O. Box 97 Odenton Md
DATE SIGNED —
PHYSICIAN'S NAME (Type) Felix Grundy

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2/20/59
22c. NAME OF CEMETERY OR CREMATORY Mt Calvary
22d. LOCATION (City, town, or county) (State) A A Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE Isaiah T Brown & Son
ADDRESS 104 W Monument
24a. REC'D BY REGISTRAR DATE FEB 20 '59
24b. REGISTRAR'S SIGNATURE Thos L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1469 — Reg. Dist. No. 01458

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 23days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Delaware
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seaford
d. STREET ADDRESS: RRD 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Elmer — Middle Roland — Last Matthews

4. DATE OF DEATH: Month 2 — Day 2 — Year 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 16, 1893

9. AGE (In years last birthday): 65
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Unknown~~ Farm Laborer

10b. KIND OF BUSINESS OR INDUSTRY: ----Farm----

11. BIRTHPLACE (State or foreign country): ~~Unknown~~ Dorches ter Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Unknown~~ William Thompson

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Clara Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ~~Unknown~~ (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 219-36-5139 (~~Unknown~~)

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Bronchopneumonia
DUE TO
(b): Cerebral Hemorrhage
DUE TO
(c): Arteriosclerotic Cardiovascular and Renal Disease with Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. ----- Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/9, 1959, to 2/2, 1959, that I last saw the deceased alive on 2/2, 1959, and that death occurred at 3:30P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 2/2/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.
Crownsville State Hospital, md. 2/2/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-7-59
22c. NAME OF CEMETERY OR CREMATORY: Thompsontown Cemetery
22d. LOCATION (City, town, or county) (State): Hurlock md.

23. FUNERAL DIRECTOR'S SIGNATURE: JJ Trampton Son Federalsburg md
ADDRESS: Thompsons -

24a. REC'D BY REGISTRAR DATE: FEB 6 '59
24b. REGISTRAR'S SIGNATURE: Wilbur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1423

CERTIFICATE OF DEATH

01460

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 25 Madison Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: I — Last: Owens

4. DATE OF DEATH: Month: 2 — Day: 10 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 3rd 1886

9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life) even if retired): Fireman Ret

10b. KIND OF BUSINESS OR INDUSTRY: City Fireman Annapolis

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Samuel Owens

14. MOTHER'S MAIDEN NAME: Clara Basil

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Ruby E. Owens — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Carcinoma of Urethra — 10 mo.
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-7-58, 19____, to 2-10-59, 19____, that I last saw the deceased alive on 2-10-59, 19____, and that death occurred at 2 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edwin Davis, Jr. M.D. — ADDRESS (Street, city or town, state): 98 Cathedral St — DATE SIGNED: 2/11/59

PHYSICIAN'S NAME (Type): Edwin Davis Jr., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-13-59

22c. NAME OF CEMETERY OR CREMATORY: St Annes Cemetery

22d. LOCATION (City, town, or county): Annapolis (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR — DATE: FEB 13 '59

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1424

01461 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ARNOLD
d. STREET ADDRESS: RT. 2 Box 597B
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leslie Middle: Grace Last: Page

4. DATE OF DEATH: Month: February Day: 8 Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 6, 1959

9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months: 2 Days: — IF UNDER 24 HRS: Hours: 18 Mins: 55

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Kenneth William Page

14. MOTHER'S MAIDEN NAME: Frances Ruth Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mother Address: Rt. 2, Box 597B, Arnold, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ERYSIPELAS — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS

C52X

DUE TO (b): STAPHYLOCOCAL SEPTICEMIA — 2 DAYS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 6, 19 59 to Feb. 8, 19 59 that I last saw the deceased alive on Feb. 8, 19 59, and that death occurred at 9:40 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): 141 CATALPA LANE, ANNAPOLIS, MD DATE SIGNED: 10 Feb 59

PHYSICIAN'S NAME (Type): STUART H. WALKER M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-10-1959

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest

22d LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John W. Layton Sons ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: FEB 13 '59

24b REGISTRAR'S SIGNATURE: Arthur S. Evans

063283X6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1425 **CERTIFICATE OF DEATH** 01463

Reg. Dist No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital
d. STREET ADDRESS: 574 W. Washington
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis

3. NAME OF DECEASED (Type or print): First Fannie Middle B. Last Queen

4. DATE OF DEATH: Month 2 Day 10 Year 1959

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4-5-1889
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Bryan
14. MOTHER'S MAIDEN NAME: Hester Matthews

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: Nellie B. Adams Address: Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion
DUE TO (b): Arterio Sclerotic Heart Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.0
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from May 1958, 19____, to 2-10, 1959, that I last saw the deceased alive on 2-10-, 1959, and that death occurred at 4:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. L. Richardson M.D.
ADDRESS (Street, city or town, state): 110 Clay St Annapolis, Md.
DATE SIGNED: 2/11/59
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-15-59
22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese, D. ADDRESS: Annap. Md.
24a. REC'D BY REGISTRAR DATE: FEB 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur P. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01464

Reg. Dist. No. 1426

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A.A. GENERAL Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 17 CATHEDRAL St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle J. — Last QUIGLEY

4. DATE OF DEATH: Month 2 — Day 28 — Year 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-19-1896

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRINTER

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt. Printer

11. BIRTHPLACE (State or foreign country): ENGLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: SAMUEL Quigley

14. MOTHER'S MAIDEN NAME: ANNA PURCELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: LESLIE A. QUIGLEY — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Sudden

4344

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E Linhardt M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 3/4/59

EXAMINER'S NAME (Type): E. Linhardt.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3-3-59

22c. NAME OF CEMETERY OR CREMATORY: CEDAR Bluff

22d. LOCATION (City, town, or county): ANNAPOLIS (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John M Taylor & Son — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: MAR 4 '59

24b. REGISTRAR'S SIGNATURE: Clifton E. Keene

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1427 **CERTIFICATE OF DEATH** 01465

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: a a — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: AA General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchton
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First BENJAMIN Middle — Last Redmiles

4. DATE OF DEATH: Month Feb Day 3 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 1/22/78
9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Patuxent MD
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lemuel Redmiles
14. MOTHER'S MAIDEN NAME: Mary Ann Shoemaker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: 579-03-4218
17. INFORMANT: ELIZABETH MORRIS Address: Churchton MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
540.0
DUE TO (b): Blood transfusion for
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
~~DUE TO~~ (c): Multiple gastric ulcers & hemorrhage — 2 Wks.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of body of Pancreas & metastases
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

MEDICAL CERTIFICATION

21. I **certify** that I attended the deceased from 2-2, 1959 to 2-3, 1959 that I last saw the deceased alive on 2-3, 1959, and that death occurred at 9:10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M Shipley M.D — ADDRESS (Street, city or town, state): 121 Cathedral St — DATE SIGNED: 2-[illegible]-59

PHYSICIAN'S NAME (Type): Frank M Shipley — Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/5/59
22c. NAME OF CEMETERY OR CREMATORY: Woodfields
22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard Hardesty — ADDRESS: Galesville Md
24a. REC'D BY REGISTRAR DATE: FEB 18 '59
24b. REGISTRAR'S SIGNATURE: Clifton L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

FOR STATE HEALTH DEPT.

Items 18-21 Film

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01466

Reg. Dist. No. 1470

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hawkins Point, Chesapeake Bay

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland — O/K
d. STREET ADDRESS: R.F.D. 2, Box 341
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN — Middle STONER — Last REXRODE

4. DATE OF DEATH: Month February — Day 23 — Year 1959

5. SEX: M

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-15-1928

9. AGE (In years last birthday): 30 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Crane hooker

10b. KIND OF BUSINESS OR INDUSTRY: Beth. Steel

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Labon C. Rexrode

14. MOTHER'S MAIDEN NAME: Fannie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W. II

16. SOCIAL SECURITY NO.: 216-22-5030

17. INFORMANT: Mrs. Doris W.Rexrode, Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowning (body found buried in sand on river bank)
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Found covered by sand on river bank on 2/23/59 Disappeared from home 12/12/58

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Found in river bank

20f. (City or town) (County) Anne Arundel (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: Charles S Petty M D

EXAMINER'S NAME (Type): Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: Feb. 24, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2-26-1959

22c. NAME OF CEMETERY OR CREMATORY: Evergreen Mem.Gardens

22d. LOCATION (City, town, or county) (State): Finksburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: C. M. Waltz, Winfield, Md.

24a. REC'D BY REGISTRAR DATE: FEB 26 '59

24b. REGISTRAR'S SIGNATURE: William E Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01467

CERTIFICATE OF DEATH

1477 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY AA MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lake Shore
c. LENGTH OF STAY IN 1b
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lake Shore Rural

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lake Shore
d. STREET ADDRESS BOX 442 Lake Shore Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Edward Middle B. Last Ray
4. DATE OF DEATH Month February Day 2 Year 1959

5 SEX M | 6. COLOR OR RACE W | 7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH 2-7-88 | 9 AGE (In years last birthday) 70 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coast Guard
10b KIND OF BUSINESS OR INDUSTRY Retired
11 BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME UNKnown
14 MOTHER'S MAIDEN NAME UNKnown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW I
16. SOCIAL SECURITY NO. 215-24-4152
17. INFORMANT Family Address Same

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Acute coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 hour
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Cardiovascular disease — 2 years
DUE TO
(c) generalized hypertrophic osteoarthritis — 2 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — WAS AUTOPSY PERFORMED? YES ☐ NO ☒
Acute urine infection - 2 days duration

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from January 15 1950 to February 2 1959 that I last saw the deceased alive on February 1, 1959 and that death occurred at 2 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE R. M. McLaughlin M.D. ADDRESS (Street, city or town, state) RFD 8 Box 442 Pasadena, Md. DATE SIGNED Feb. 2, 1959
PHYSICIAN'S NAME (Type) R. M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2-5-59
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem
22d LOCATION (City, town, or county) (State) Baltimore, MD.

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS McCully Funeral Home 130 E. Fort Ave.
24a. REC'D BY REGISTRAR DATE FEB 3 '59
24b REGISTRAR'S SIGNATURE Carl S. Kramer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. funeral director, uld be filed with

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01468

1428 **CERTIFICATE OF DEATH**

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: A. A. County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN Jb:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A.A. General Hosp
d. STREET ADDRESS:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — COUNTY: A. A. County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis Maryland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Vincent Middle Eric Last Roberts

4. DATE OF DEATH: Month 2 Day 21 Year 1959

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-1-1958

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months 4 Days; IF UNDER 24 HRS. Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Richard Roberts Jr.

14. MOTHER'S MAIDEN NAME: Arline Williams

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Arline Williams — Address: 91 East St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Status epilepticus — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

571.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): acute electrolyte disturbance — 2 hrs.

DUE TO (c): Hyperpyrexia and sudden diarrhea — 18 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 21 Feb, 1959, to 21 Feb, 1959, that I last saw the deceased alive on 21 Feb, 1959, and that death occurred at 7:00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James I Hudson, Jr. M.D. — ADDRESS (Street, city or town, state): River Club Estates — DATE SIGNED: 23 Feb 59

PHYSICIAN'S NAME (Type): James I. Hudson, Jr. — Edgewater, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 2-24-1959 — 22c. NAME OF CEMETERY OR CREMATORY: Brewer Hall — 22d. LOCATION (City, town, or county): Annapolis (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm Reese #. — ADDRESS: 108 Washington St. Anna. Md.

24a. REC'D BY, REGISTRAR — DATE: FEB 25 59

24b. REGISTRAR'S SIGNATURE

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1472

CERTIFICATE OF DEATH

Reg. Dist. No. 01469

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena
c. LENGTH OF STAY IN 1b 48 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) R.F.D. #3 - Box 1 Mountain Road

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Md.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena
d. STREET ADDRESS Mountain Road
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print) First MYRTLE Middle MARIE Last SCHRAMM

4. DATE OF DEATH Month Feb Day 22 Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH May 20. 1899
9. AGE (In years last birthday) 59 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Baltimore City
12. CITIZEN OF WHAT COUNTRY? —

13. FATHER'S NAME Edgar Clark
14. MOTHER'S MAIDEN NAME Elizabeth Derrendeger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO none
17. INFORMANT William M. Schramm Address Mountain Rd Glen Burnie Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Liver. — INTERVAL BETWEEN ONSET AND DEATH about 6 months
156.1
DUE TO (b) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
—

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) (County) (State) —

21. I certify that I attended the deceased from Nov, 1958, to Feb 22, 1959, that I last saw the deceased alive on Feb 22, 1959, and that death occurred at 5 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE James S. Bullington M.D. ADDRESS (Street, city or town, state) 108 Curtis Av Glen Burnie Md DATE SIGNED
PHYSICIAN'S NAME (Type) James S. Bullington 108 Curtis Av Glen Burnie Md Feb 23 1959

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Feb-25-1959
22c. NAME OF CEMETERY OR CREMATORY Loudon Park
22d. LOCATION (City, town, or county) Baltimore City (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE John F. Feigel ADDRESS 5311 Edmondson Ave.
24a. REC'D BY REGISTRAR DATE FEB 25 '59
24b. REGISTRAR'S SIGNATURE E. K. Kaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01470

Reg. Dist. No. 1473

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 1 yr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 112 Jerome Parkway

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 112 Jerome Parkway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: GERTRUDE — Middle: L. — Last: SEHLHORST

4. DATE OF DEATH: Month: February — Day: 2 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 3 1903

9. AGE (In years last birthday): 55 yrs

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Drug

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Sehlhorst

14. MOTHER'S MAIDEN NAME: Matilda Trossbach

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-09-2319

17. INFORMANT: Fred Sehlhorst — Address: 112 Jerome Pkwy

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Alcoholism.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Paul F. Guerin M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 2/2/59

EXAMINER'S NAME (Type): Paul F. Guerin, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Feb 5-59
22c NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem
22d LOCATION (City, town, or county) (State): Belair Rd Balto Md

23 FUNERAL DIRECTOR'S SIGNATURE: Bernard A Fink — ADDRESS: Glen Burnie Md

24a. REC'D BY REGISTRAR: DATE: FEB 4 '59
24b REGISTRAR'S SIGNATURE: Arthur S. Kness

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1429

CERTIFICATE OF DEATH

Reg. Dist. No 0141

1. PLACE OF DEATH
a. COUNTY: Anne Ayundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ARNOLD ANNAPOLIS
c. LENGTH OF STAY IN 1b: 24hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne ARVNDEL GENERAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ARNOLD, Md.
d. STREET ADDRESS: R.R. #1, Box 254
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First TERRY Middle Lee Last SHOPE

4. DATE OF DEATH: Month 2 Day 28 Year 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-14-48

9. AGE (In years last birthday): 10 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: EARL M. SHOPE

14. MOTHER'S MAIDEN NAME: Martha L. Morris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: FATHER
Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ___ INTERVAL BETWEEN ONSET AND DEATH: ___
DUE TO (b) ___ : ___
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 493X
DUE TO (c) Pneumonia : 2 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Febr. 27, 1959, to Febr. 28, 1959, that I last saw the deceased alive on Febr. 28, 1959, and that death occurred at 8:20 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clayton Norton M.D. ADDRESS (Street, city or town, state): Med. Arts Bldg. DATE SIGNED: 2-28-59

PHYSICIAN'S NAME (Type): Clayton Norton Severna Park, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried
22b. DATE THEREOF: March 4, 1959
22c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery
22d. LOCATION (City, town, or county) (State): Oakland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Singleton Funeral Home ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: MAR 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Item 20 Film 239 3-6-59 ams

1474

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01472

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT GEO. G. MEADE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. ARMY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X FORT GEO. G. MEADE
d. STREET ADDRESS: Co A USA Support Element
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard — Middle: — Last: Silverman

4. DATE OF DEATH: Month: February Day: 25 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 14 May 1937

9. AGE (In years last birthday): 21 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: U. S. ARMY

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ralph Silverman

14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): Yes 26Nov56 to date

16. SOCIAL SECURITY NO.: 357-28-5644

17. INFORMANT: Personnel Records Address: Ft George G. Meade, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: DOA

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Carbon Monoxide Inhalation

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Subject apparently committed suicide by sitting in car with engin running and doors closed

20c. TIME OF INJURY Month, Day, Year Hour o m: 0055XXXX Feb 25 1959

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.): Near Bldg T-48

20f (City or town) (County) (State): FORT GEO. G. MEADE AA MD

21. I certify that I attended the deceased from 25 Feb 59 to 25 Feb 59 that I last saw the deceased alive on ____ 19____, and that death occurred at 0055 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Myron J. Myers M.D. ADDRESS (Street, city or town, state): USAH, Ft. G. G. Meade, Md DATE SIGNED: 25 Feb 59

PHYSICIAN'S NAME (Type): MYRON J MYERS, MD USAH Ft George G. Meade, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

22b. DATE THEREOF: 2-26-59

22c NAME OF CEMETERY OR CREMATORY: Mt. Sinai Cemetery

22d. LOCATION (City, town, or county) (State): St. Louis, Missouri

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: William Cook, Inc., 1217 St. Paul Street

24a REC'D BY REGISTRAR DATE: MAR 2 '59

24b. REGISTRAR'S SIGNATURE: Clint L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1475 — Reg. Dist. No. 0147

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 3m0.3yrs.14days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaPlata
d. STREET ADDRESS: ?
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: James — Middle: A. — Last: Small

4. DATE OF DEATH: Month: 2 — Day: 23 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/28/71

9. AGE (In years last birthday): 87 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Joseph Small

14. MOTHER'S MAIDEN NAME: Henrietta Grey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-18-8402

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 72 Hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Advanced Cerebral Arteriosclerosis — 5-10 years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypostatic Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ———

20c. TIME OF INJURY: Hour a. m. p. m. ——— Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ———

20f. (City or town) (County) (State) ———

21. I certify that I attended the deceased from 11/9 19 55 to 2/23 19 59, that I last saw the deceased alive on 2/23 19 59, and that death occurred at 7:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Leonardo Garcia-Bunuel, M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 2/23/59

PHYSICIAN'S NAME (Type): Leonardo Garcia-Bunuel — Crownsville State Hospital, Md. — 2/23/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-27-59
22c. NAME OF CEMETERY OR CREMATORY: St. Joseph's Cem.
22d. LOCATION (City, town, or county) (State): Pamphlet, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Milton E. Blicken — ADDRESS: 1129 N. Caroline St,

24a. REC'D BY REGISTRAR DATE: FEB 25 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1430 **CERTIFICATE OF DEATH** Reg. Dist. No. 01474

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Riva
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle Bryant — Last Snead

4. DATE OF DEATH: Month February — Day 20 — Year 21 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 20, 1959

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months — Days 1 — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gilbert Floyd Snead

14. MOTHER'S MAIDEN NAME: Arline Louise ~~Erheart~~ Erheart

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mother — Address: Riva, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Mediastinal emphysema + bilateral pneumothorax — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Spontaneous alveolar rupture near perihilar vessels — 2 hrs.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 21 Feb, 19 59, to 21 Feb, 19 59, that I last saw the deceased alive on 21 Feb, 19 59, and that death occurred at 3:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James L Hudson Jr. M.D. — ADDRESS (Street, city or town, state): River Club Estates — DATE SIGNED: 23 Feb 59

PHYSICIAN'S NAME (Type): James L. Hudson, Jr. — Edgewater, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-24-59

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Prince George Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: FEB 25 59

24b. REGISTRAR'S SIGNATURE

44-2X.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1431 Item 1 211.3238 2-13-59 et

CERTIFICATE OF DEATH

Reg. Dist. No. 01475

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Md b. COUNTY: ANNARUN'd I.E.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis	c. LENGTH OF STAY IN 1b: 2 days
	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X SEVERNA-PARK
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hosp.	d. STREET ADDRESS: 1001d County Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐
3 NAME OF DECEASED (Type or print): First FRANCES Middle E Last STEWART	4. DATE OF DEATH: Month 2 Day 5 Year 1959
5. SEX: FEMALE	6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH: APRIL 18 1886
9. AGE (In years last birthday): 72 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE	10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country): VA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: CHARLES PERKINS	14 MOTHER'S MAIDEN NAME: —
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service)	16. SOCIAL SECURITY NO: —
17. INFORMANT: JOSEPH S. STEWART Address: SEVERNA PK ANNE ARUNDEL CO. MD.	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ACUTE PULMONARY EMBOLUS — INTERVAL BETWEEN ONSET AND DEATH: 3 DA.

465 X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2/4, 1959, to 2/5, 1959, that I last saw the deceased alive on 2/5, 1959, and that death occurred at 4:20 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard N Reeler M.D. ADDRESS (Street, city or town, state): 121 CHURCH ST DATE SIGNED: 2/5/59

PHYSICIAN'S NAME (Type): RICHARD N. REELER ANNAPOLIS MD

22a BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)	
BURIAL	2/8-59	ELTIS CHURCH	PERKINSVILLE	VA

23. FUNERAL DIRECTOR'S SIGNATURE: FRANK W. SEITZ ADDRESS: 814 N. Gay St Baltimore 11 Md

24a. REC'D BY REGISTRAR DATE: FEB 9 '59

24b. REGISTRAR'S SIGNATURE: C. M. & Kinna

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1432

CERTIFICATE OF DEATH

01476 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/58

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis,
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel Gen'l. Hosp.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pasadena, RFD
d. STREET ADDRESS: Rt. 9 Box 359,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EARL Middle R. Last TAYLOR

4. DATE OF DEATH: Month February Day 20, Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 24, 1898

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Self Emp.

11. BIRTHPLACE (State or foreign country): Riverton, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward R. Taylor

14. MOTHER'S MAIDEN NAME: Florence E. Ellinsworth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

INFORMANT Address: Mr. James M. Taylor, Pasadena, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory failur — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): Cor pulmonary emphysema + fibrosis — 10 yrs.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 527.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year 19 Hour o m. p. m.

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/18, 19 59, to 2/20, 19 59 that I last saw the deceased alive on 2/20, 19 59, and that death occurred at 2:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John P. Hedemen, M.D. ADDRESS (Street, city or town, state): 121 Cathedral — DATE SIGNED: 2/20/59

PHYSICIAN'S NAME (Type): John P. Hedemen — Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 23/59

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery

22d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Richard W. Singleton — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: FEB 26 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01477

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1476

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 301 Highway
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore, Md
d. STREET ADDRESS: 420 n. Green st.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: W. — Last: Teat
4. DATE OF DEATH: Month: 2 — Day: 12 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/ 107
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaac Teat
14. MOTHER'S MAIDEN NAME: Margaret Murray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-03-0637
17. INFORMANT — Address: Margaret White, Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 8250 multiple contusions. Crushed skull
DUE TO (b): auto accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour 1:46 a. m. p. m. — Month, Day, Year: 2-12-1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☑
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Road (highway)
20f (City or town) (County) (State): Rt 301 at Severn Run Rd AA Co Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Emily H. Wilson — M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☑
EXAMINER'S NAME (Type)
DATE SIGNED: 2-12-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/16/59
22c. NAME OF CEMETERY OR CREMATORY: Gouldtown Cem
22d. LOCATION (City, town, or county) (State): Carrollton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James L. Dashiell, Easton, Md.
24a. REC'D BY REGISTRAR DATE: FEB 24 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krantz

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be recorded in the Chief Medical Examiner's Office along with form #M3. Page 5 may be retained for your files
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1477 **CERTIFICATE OF DEATH** 01478

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1yr. 1mo. 27days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 678 Bradley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Abraham — Middle — Last Toliver
4. DATE OF DEATH: Month 2 — Day 3 — Year 1959
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 1902
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): worked for a junkman
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Toliver
14. MOTHER'S MAIDEN NAME: Lizzie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes Discharged:1919
16. SOCIAL SECURITY NO: 218-14-6576
17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Paralytic Ileus — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO (b): Embolia and Thrombosis of Mesentric Vessels
DUE TO (c): Cardiac failure associated with Arteriosclerotic Cardiovascular Disease
422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ---
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): ---
20c. TIME OF INJURY Hour o. m. p. m. ---- Month, Day, Year 19 ----
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----
20f. (City or town) (County) (State) ----

21. I certify that I attended the deceased from 12/6 1957 to 2/3 1959, that I last saw the deceased alive on 2/3 1959, and that death occurred at 6:45P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 2/4/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D. — Crownsville State Hospital, Md. — 2/4/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/9/59
22c. NAME OF CEMETERY OR CREMATORY: Baltimore National
22d. LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE: Charles R. Law — ADDRESS: 802 Madison Ave
24a. REC'D BY REGISTRAR — DATE: FEB 10 '59
24b. REGISTRAR'S SIGNATURE: Curtis E. Evans

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1478

01479
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wild Rose Shore
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis R.7 Box
d. STREET ADDRESS: Wild Rose Shore
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret Middle: Last: Toohey
4. DATE OF DEATH: Month: 2 Day: 18 Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug 28th 1870
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Courtney
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Address: Mrs John J. Lausch (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): pneumonia (lobar) — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 4 days respiratory infection — 3 days
DUE TO
(c) Cor. arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m., 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 21st, 19 55, to Feb 16th, 19 59, that I last saw the deceased alive on Feb 16th, 19 59, and that death occurred at 7:40 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edith A. Gallup M.D. ADDRESS (Street, city or town, state): 45 Franklin St. Annapolis, Md. 21403 DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feby 21-59
22c. NAME OF CEMETERY OR CREMATORY: St. Johns
22d. LOCATION (City, town, or county): Brooklyn (State): N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons ADDRESS: Annapolis Md
24a. RECD BY REGISTRAR DATE: FEB 24 59
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1479 — 01480 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 35yr 8mo 24da
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Violet — Middle: — Last: Trusty

4. DATE OF DEATH: Month: 2 — Day: 9 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1902?

9. AGE (In years last birthday): 56? yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): Unknown — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Dilatation of Stomach — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
155.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carcinoma of Ampulla of Vater
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ----------

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----------

20c. TIME OF INJURY: Hour: — o. m. / p. m. — Month: — Day: — Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ------

20f. (City or town) (County) (State): ----------

21. I certify that I attended the deceased from 6/15 19 23 to 2/9 19 59, that I last saw the deceased alive on 2/9 19 59, and that death occurred at 1:50A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 2/9/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D. — Crownsville State Hospital, Md. — 2/9/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb 12th 1959
22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph L. Rubs — ADDRESS: 1222 W. North ave

24a. REC'D BY REGISTRAR: DATE FEB 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Howe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

D. 1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01481
Reg. Dist. No.

1480

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park
c. LENGTH OF STAY IN 1b 23 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY Anne Arundel
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Earleigh Hgts.
d. STREET ADDRESS Truck House Road
e IS RESIDENCE ON A FARM? YES ☑ NO ☐

d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —

3. NAME OF DECEASED (Type or print) First James Melvin Middle Walbeck Last
4. DATE OF DEATH Month 2 Day 12 Year 1959
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Aug 20-1894
9. AGE (In years last birthday) 64 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Poultry
10b KIND OF BUSINESS OR INDUSTRY Farmer
11. BIRTHPLACE (State or foreign country) Harford Co. Md
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Adam G Walbeck
14 MOTHER'S MAIDEN NAME Cora Delevett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War I
16. SOCIAL SECURITY NO. —
17. INFORMANT Julia J Walbeck Address Severna Park Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary disease — INTERVAL BETWEEN ONSET AND DEATH Sudden
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED White at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE E Linhardt M.D.
EXAMINER'S NAME (Type) E Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 2/12/59

22a. BURIAL CREMATION REMOVAL (Specify) Burial
22b DATE THEREOF Feb 16-59
22c. NAME OF CEMETERY OR CREMATORY Deer Creek
22d. LOCATION (City, town, or county) Chestnut Hill (State) Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Mahlon E Watts ADDRESS Jarrettsville Md
24a. REC'D BY REGISTRAR DATE FEB 19 '59
24b REGISTRAR'S SIGNATURE Arthur S. K.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, as designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1481 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01482

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY A.A.Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Jones Station
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE M b. COUNTY A.A.Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Jones Station
d. STREET ADDRESS Rt 408, Generva P.K.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Nettie Middle B Last White

4. DATE OF DEATH Month 2 Day 24 Year 19 57

5. SEX F

6. COLOR OR RACE C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 12-31-1880

9. AGE (In years last birthday) 78 yrs

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) A.A.Co.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henson Brown

14. MOTHER'S MAIDEN NAME Charlotte Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO —

17. INFORMANT Address Theodore White Generva P.K.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Disease — INTERVAL BETWEEN ONSET AND DEATH Sudden

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o m p m Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE [signature] M.D.

EXAMINER'S NAME (Type) F. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 2/24/57

22a. BURIAL CREMATION REMOVAL (Specify) BURIAL

22b. DATE THEREOF 3-1-59

22c. NAME OF CEMETERY OR CREMATORY Carpenters Hill

22d. LOCATION (City, town, or county) (State) Jones - A.A.Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE Charles F. Hicks III ADDRESS Anna, Md

24a. REC'D BY REGISTRAR DATE MAR 2 '59

24b. REGISTRAR'S SIGNATURE [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1482

CERTIFICATE OF DEATH

01483

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Fredrick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fredrick
d. STREET ADDRESS: 179 W. All Saints Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Mary — Middle — Last Williams

4. DATE OF DEATH: Month 2 — Day 10 — Year 1959

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 1892

9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovascular Disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): ---

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m.: ---

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---

20f. (City or town) (County) (State): ---

21. I certify that I attended the deceased from 1/22/ 1959 to 2/10 1959, that I last saw the deceased alive on 2/10 1959, and that death occurred at 4:42A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE, M.D.: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 2/10/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.
Crownsville State Hospital, Md. 2/10/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-14-59
22c. NAME OF CEMETERY OR CREMATORY: Hope Hill
22d. LOCATION (City, town, or county) (State): Frederick Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Hicks III — ADDRESS: Frederick, Md.

24a. REC'D BY REGISTRAR DATE: FEB 17 '59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [redacted] page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1483 — Reg. Dist. No. 01484

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn 25
c. LENGTH OF STAY IN 1b: 1½ year
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 212 Riverside Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 50 — Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William — Middle E. — Last Wolfe

4. DATE OF DEATH: Month February — Day 7th — Year 19 59

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 10/8/59 10-8-1878 — 9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Telegraph Operator, P.R.R. — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country): Johnstown, Penn. — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph E. Wolfe — 14. MOTHER'S MAIDEN NAME: Margaret E. Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No — 16. SOCIAL SECURITY NO.: None — 17. INFORMANT: Address: Mrs. Myra Reilly (Niece) 216 Riverside Rd. Brooklyn

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): General Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: ?

450.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m., p. m., Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave K Faubert M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 2/7/59

EXAMINER'S NAME (Type): Gustave K. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal — 22b. DATE THEREOF: 2-8-59 — 22c. NAME OF CEMETERY OR CREMATORY: HOLY SEPULCHRE — 22d. LOCATION (City, town, or county) (State): WYNDMOOR, PA.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm J. Tickner & Sons. — ADDRESS: North & Pa. Aves Balto. M. Md. — 24a. REC'D BY REGISTRAR DATE: 9 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur S Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1433

Reg. Dist. No. 01485

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ANNE ARUNDEL GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL CO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 ANNAPOLIS
d. STREET ADDRESS: 4 CUMBERLAND COURT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET — Middle TAYLOR RANDALL — Last WORTHINGTON

4. DATE OF DEATH: Month FEBRUARY — Day 17 — Year 19 59

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JAN. 14, 1861

9. AGE (In years last birthday): 98 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: BURTON RANDALL

14. MOTHER'S MAIDEN NAME: VIRGINIA TAYLOR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT — Address: VIRGINIA R. WORTHINGTON #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 13 days
DUE TO
(b): Senility & dehydration — 3 yrs
DUE TO
(c): Dehydration — 4 days

434.4

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Violent uncooperative, IV fluids impossible

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell on attempting to rise from her chair

20c. TIME OF INJURY Month, Day, Year: Hour a. m. 1030 — p.m. — Feb 4 19 59

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Annapolis (County) Anne Arundel (State) Md.

21. I certify that I attended the deceased from Feb 4, 19 59, to Feb 17, 19 59, that I last saw the deceased alive on Feb 16, 19 59, and that death occurred at 1:24 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Harold R Bohlman M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: Feb 18, 1959

PHYSICIAN'S NAME (Type): Harold R. Bohlman MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/19/59
22c. NAME OF CEMETERY OR CREMATORY: ST. ANNES
22d. LOCATION (City, town, or county) (State): ANNAPOLIS, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: JOHN M. TAYLOR AND SONS ANNAPOLIS, MD.

24a. REC'D BY REGISTRAR DATE: FEB 24 59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS